ROEHAMPTON REHABILITATION CENTRE

IN*/OUT*-PATIENT PROSTHETIC REHABILITATION REFERRAL

*Delete as appropriate. If not deleted, will assume out-patient referral

PLEASE ENSURE ALL SECTIONS OF THE FORM ARE COMPLETED

TO: Dr Vijay Kolli
Locum Consultant in rehabilitation medicine
Roehampton Rehabilitation Centre
Roehampton Lane
London SW15 5PN
Tel: 020 8487 6030
Email: caroline.thomas1@nhs.net
sarah.smith50@nhs.net

FROM: **Consultant:**
Hospital:
Ward:
Contact No:
Bleep:

1 To be completed by Medical Staff

NHS Number		Date of Hospital Admission	
Patient's Name		Date of Amputation	
		Date of Hospital Discharge	
Male / Female			
Address		Discharge Address	
Post Code		Post Code	
Tel No		Tel No	
Date of Birth		Occupation	
GP's Name		Single / Married / Divorced / Widowed / Partner	
Address		Name of Next of Kin	
Post Code		Post Code	
Tel No		Tel No	

Is the patient well enough to attend the Roehampton Rehabilitation Centre? YES / NO

	Lower Limb	Upper Limb
Amputation Level	L	R
	R	L

Amputation Technique (mark where appropriate): Myoplastic / Skew Flaps / Simple Flaps / Other

Cause of Amputation

Primary		Revision	

P.M.H. + H.P.C.

Drug Treatment

Height — Weight

	YES	NO		YES	NO
Visual Impairment			Interpreter required		
Hearing Impairment			Language:		

2 To be completed by Nursing Staff

Condition of Stump (mark where appropriate)	HEALED	YES	NOT HEALED	Infected
		NO		Clean and granulating

	YES	NO
Stump Pain		
Phantom Pain		
Diabetic		
Smoker:		
MRSA		

Alcohol: YES / NO / Units per week

TYPE: 1 / 2

Date given up

Date of last screen

Continence	CONTINENT		URINARY CONTINENCE		FAECAL CONTINENCE	
Pressure Care	Waterlow Score		Using airless mattress?	YES		NO
Pressure Sore	YES	NO	if yes: infected / clean and granulating			

Condition of remaining leg

Chiropody referral / care: YES / NO

Any other Nursing information:

3 To be completed by Therapists

Lower Limb

Therapy Information - For upper limb amputee please attach therapy report

	YES	NO
Is the patient safe and independent in using a wheelchair?		
Is the patient independent in washing and dressing?		
Can patient transfer independently from any surface using a standing pivot transfer?		
If not please state method of transfer		
Is patient able to push up from sitting in wheelchair to stand independently in parallel bars?		
Has the patient started using an EWA within parallel bars?		
Does the patient have a Hip Flexion Contracture greater than 25 degrees ?		
Is the patient cognitively unimpaired?		
Has wheelchair been ordered?		
If Yes, type:		
Has home visit been carried out?		

Please supply copy report. If unable, please attach summary of social or housing situation.

CONTACTS	NAME	CONTACT No.	BLEEP	Report enclosed YES	NO
Physiotherapist:					
Occupational Therapy:					
Psychology:					

Any other relevant information from the referring team:

Please indicate that if admitted but subsequently does not respond to intensive rehabilitation, within a period of 2/52, the referring hospital will take the patient back.

I agree to accept the patient back if not considered appropriate for the amputee rehabilitation service or when he/she has not achieved their optimal functional level; or when optimal function is achieved but social problems are preventing discharge home.

Name of Consultant:

Signature: Date: